A degree of anæmia is not at all uncommon in cases of congestive failure, and it is surprising how the patient's cardiac condition improves, when it is treated. This is well illustrated by a male patient of mine, aged 80, with long-standing aortic regurgitation, who developed auricular fibrillation and congestive failure. Although this was adequately controlled, he became more and more lethargic, sleeping most of the day and only being roused with difficulty, for meals and conversation. His Hb level was found to be 50%, with an iron deficiency type of anæmia. There was no response to iron by mouth, but a rapid recovery followed intravenous injections of saccharated iron oxide, which raised the Hb level to 89% in three weeks.

Conclusion.—The essence of treatment in most cardiac emergencies is embodied in a comprehensive knowledge of the treatment of ischæmic heart disease and of cardiac failure.

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DISCUSSION ON THE MANAGEMENT OF THE ALCOHOLIC IN GENERAL PRACTICE

Dr. J. Yerbury Dent: On entering general practice, my father handed me those addicts who had been a trouble to him for many years and I had plenty of opportunity to get to know them and try various ways of giving them apomorphine. I thought I might sicken the drinker of alcohol by limiting his intake to that and nothing else and by following each potation with a vomit induced by an injection of apomorphine I would produce a conditioned aversion.

By giving apomorphine before alcohol an aversion to it can be produced in most people but it is very transient and slight and sometimes there is none at all. Some alcoholics are not sick even with big doses of apomorphine, up to half a grain intramuscularly, and I have had one who had no sense of smell and did not know whether his drink contained any spirit or not and so could not develop an aversion to it. The success of apomorphine does *not* depend on a conditioned aversion and it is the only treatment of addiction to alcohol that is successful in the treatment of addictions to morphine and other cerebral sedatives.

It is also useful in hysteria and in the possible biochemical disturbances which may accompany anxiety and misery, and in puerperal mania. It has also been given for the morning sickness of pregnancy and for seasickness. I have had many alcoholic patients with albuminuria up to 2% which has cleared up entirely during the week's treatment. I gave it to myself when I was in acute misery, with satisfactory results: I put these down to removal of undigested food and the sleep that followed. A post-partum maniacal case that had shrieked for two days and nights and refused to feed her baby and tried to destroy it because she said it was dead, was given one-tenth of a grain and she was asleep in ten minutes. I woke her an hour later after having given the baby the breast and she was perfectly sane and she had not vomited at all. She remained sane and has had two more children without trouble. A woman my father had known from birth, aged 40, had been married for eighteen years. She and her husband had longed for a child and had gone everywhere for advice. They were very much in love but unhappy because of their longing. She was waiting for him to come home to dinner when she was rung up by the police to tell her that her husband had shot himself through the head in his car. She went mad. She tried to throw herself out of the window and by the time I got to her she was fighting with her maid, the porter of the flats and her mother, her clothes were in ribbons and she was shrieking. I gave her one-tenth grain of apomorphine and she was sick and then slept. I returned two hours later and gave her a second dose. She again was sick and slept. She was perfectly sane the next day, identified the body, went through all the beastliness of the inquest and never needed any further medical or psychological help; not even after reading a letter her husband had left for her saying that he had that afternoon discovered that he could never have a child and perhaps it was not too late for her to marry again and get one. Cases like these made me think that some readjustment in blood chemistry had been produced through stimulation of the hind-brain.

Feldmann (1953) in Geneva, who has treated over a thousand addicts with apomorphine under a government scheme, has published the effects of apomorphine in normalizing the percentage of

various substances in the blood serum. The question now is—is the humoral imbalance the cause or the result of addiction. Alcohol by anæsthetizing the repressive action of the fore-brain on the diencephalon could temporally produce greater activity in the latter while the alcohol was present.

Treated alcoholic patients will relapse if they take alcohol even in small doses. I had one patient who drank heavily for years after being heartlessly jilted and, though a publican, had remained teetotal for eleven years after treatment and then, becoming again engaged to be married, was pestered by his lady to take a glass of sherry with her to drink to their mutual happiness. He protested that he dared not take it. He had told her of his previous troubles but she said that he surely could trust himself now and she would not marry a coward and persuaded him to drink. The next day he drank a bottle of whisky and then more the next, and she threw him over as she would not marry a drunkard and he drank still more and had to be treated again. He was afterwards teetotal but remained a bachelor.

As I believe that apomorphine is much more quickly eliminated from the body than alcohol and as alcoholics so suddenly relapse even after small doses, I then continued the apomorphine injections for two days after stopping the alcohol, which I still give in the first stage of the treatment, and got better results, even if they vomited their soft drinks, and so risked developing an aversion to them.

I also found that morphine and heroin addicts could be detoxicated in a week with very slight deprivation symptoms under apomorphine and that even these slight symptoms could be prevented almost entirely if alcohol were given with the apomorphine in exactly the same way as if I were treating an alcoholic. It is five and a half years since I treated my first morphine addict in this way and he has not relapsed.

These and many other different cases destroyed the theory that the production of a conditioned aversion was the main effect of apomorphine.

Then I began giving apomorphine sublingually or in the pouch of the cheek. Now I treat quite 75% of the addicts who come to me with apomorphine by mouth.

Most general practitioners at present do very little for their alcoholic patients. This is because students are taught very little on this subject. In spite of the enormous literature on addiction, very little gets into our medical textbooks. The public, thanks partly to the exertions of Alcoholics Anonymous, is being educated and it is now realized that addiction is a disease, however much drunkenness may be a moral lapse.

The general practitioner can do a great deal for his addicted patients.

First, he has to diagnose between the self-indulgent drinker, and the alcoholic addict, the compulsive drinker. The former can be helped by aversive treatments such as the conditioned aversion following emetine plus alcohol, as favoured in the United States or the Antabuse of Scandinavia, which punishes the taker of alcohol with acute acetaldehyde poisoning.

I have found that some excessive drinkers can cut down, or even cut out, their drinking by taking *carbachol* 1, 2, or 3 tablets, taken before lunch, tea and bed-time. I should like to hear more about this most physiological of the fore-brain sedatives.

Antabuse does not remove craving, the necessity for drink. I have met two cases, both addicts, both married to women doctors, who conscientiously saw that their husbands took their Antabuse regularly. Their craving was such that this did not stop their drinking, and one developed large scotomata and auditory neuritis before giving up his Antabuse; the other died of acetaldehyde poisoning a month or so after his marriage.

If it is decided to treat a drinker with Antabuse the doctor should carefully try out the effects of alcohol after small doses and not distribute it in the carefree way so many scatter their barbiturates.

Barbiturates should not be given to alcoholics except during delirium tremens, as they may easily switch their addiction to the stronger drug. There are, I am sorry to say, proud teetotal members of A.A. who now take their daily whack of phenobarbitone.

For the compulsive drinker at present I know of nothing as effective as apomorphine in removing the compulsion, the *need* for alcohol and in the milder cases of addiction, those who still eat fairly well, who have not developed polyneuritis and those who can be without alcohol for a week or more occasionally with no marked jitteriness or fear of D.T.s. These should be given apomorphine sublingually.

One-tenth of a grain tablet by Parke, Davis or B.D.H. (other brands may not be so soluble) is placed under the tongue or in the pouch of the cheek and, though it breaks up almost at once, it and the saliva are swallowed only after ten minutes. One hour later two tablets are taken in the same way. After a further hour three tablets, and so on, increasing by one tablet every hour until dose X tablets is reached, which produces vomiting. After this ¾ of X is taken every two hours while awake until the next day when the dose is pushed up again by one tablet every hour until a second vomit is produced by dose Y. After this ¾ of Y is given every two hours while awake for three days and nights from Y. But if Y is not greater than 1½ times X then two days and nights from Y will be sufficient.

An overdose cannot be taken by mouth because it would automatically remove itself, but I have known rare patients that have not been sick with a dose of 3 grains (30 tablets) at hourly intervals: all they complained of was that they felt a little dizzy. I do not advise patients to go further than 20 tablets, i.e. 2 grains two-hourly for three days and nights.

During the treatment the patient takes ordinary food but *no* alcohol. He stays indoors while he is experimenting to find his vomiting dose but once this is found he may go to his work as usual if he can arrange to be undisturbed for ten minutes every two hours. He need not be wakened for his medicine but should have little heaps of it by his bed so that if, and as soon as, he wakes he can put the next heap into his cheek and go to sleep again.

During the first twenty-four hours he may have a craving for drink, in this case he should stay in bed and on the second day his craving will be much less or have gone entirely but he should continue for the full three or four days.

This is the treatment of choice for those who relapse after the more drastic treatment by injection. There are rare cases who develop sensitivity to apomorphine with swelling and soreness of the tongue and mouth. I have never seen this at the first treatment but I have seen it in relapsed cases and I know of no method of combating it. Antihistamines relieve it only slightly.

The mouth treatment can be given even by the most busy general practitioner and it is safe and highly effective if the patient carries it out honestly. If there is any doubt that he will do this his wife or a nurse may give him the necessary moral support.

All alcoholic cases need glucose and vitamin B_1 100 mg. daily, and possibly the whole B complex. They should be encouraged to take wholemeal bread with jam or marmalade, Bemax and Marmite. It is often advisable, if possible, to give them these for a few weeks before any apomorphine treatment. They are then less likely to develop D.T.s and their polyneuritis is combated. Some suffer from pellagra, some have Korsakoff's or Wernicke's syndrome and need nicotinamide and B_{12} as well as B_1 and the G.P. should see that they continue to get the necessary vitamins after they return to normal life.

The compulsive drinker who has polyneuritis, who cannot face life for a day without alcohol, and therefore who is certainly liable to have D.T.s, should be treated with apomorphine by injection and alcohol by mouth in a home or hospital. If the G.P. has the time, and it should not need more of his attention than an ordinary obstetric case, he should give the ordinary intramuscular apomorphine treatment in a nursing home under expert nurses. The dramatic change in his patient in under a week is very rewarding and interesting to watch.

At present there are in the United Kingdom only about half a dozen beds (in St. Luke's Hospital, Woodside Avenue) where efficient treatment is available under the National Health Scheme. Some degree of psychotherapy is certainly very helpful. I always give my patients a few minutes waking suggestion as a slight insurance against their taking alcohol by mistake. Thus I tell them that they will not miss alcohol—that they are proud of not needing it and are happy without it—that they love their families and enjoy their food. A lot of trite remarks perhaps, which their conscious critical mind distrusts but would like to accept. The best way of enabling them to do this is to repeat these suggestions while they are reading a newspaper aloud. When a man is reading he is to a certain extent in a trance—a trance that he has already learnt to achieve. Waking suggestion is the easiest and simplest form of hypnosis.

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Dr. J. A. Hobson:

I believe it is true that alcoholics are never cured by psychoanalysis alone, and that the time for analytical treatment, if it is needed at all, is only *after* the alcoholic has become teetotal. But though psychoanalytic technique is unnecessary, even unwise, psychotherapy of some form is still essential if we are to treat our alcoholics adequately. Psychological factors in the doctor-patient relationship are the most important determinants of success in the treatment of the patient. And any G.P. who is worth his salt is capable of using psychotherapy of this type—and should be capable of using it successfully with his alcoholic patients.

Many alcoholics are coerced, unwillingly, by their relatives to visit their medical practitioner, and consequently are often suspicious and guarded, sometimes openly antagonistic, but unless the G.P. can win the confidence of these patients, he fails.

If the patient is fully co-operative and really desirous of cure the way the first interview is conducted is all-important in determining the ultimate success of treatment—at least as important in deciding what drug to use in subsequent therapy.

Winning of the patient's confidence and co-operation should be the primary aim of the first interview and thoroughness of examination and accuracy of diagnosis must take a place of secondary importance. Over-questioning, and over-meticulous psychiatric history-taking in the first interview loses many possibly treatable patients.

Accuracy of diagnosis and assessment of causative factors in a case of alcoholism is certainly important and of great academic interest, but it must be postponed if there is any risk of diagnostic history-taking antagonizing the patient. It is doubtful whether it is possible to make a reliable estimate of diagnosis and ætiology whilst the patient is still drinking.

Most alcoholic patients show some evidence of psychological abnormality, but it is seldom, if

ever, possible before treatment to determine whether the alcoholism is secondary to the neurosis, or the neurosis to the alcoholism. I feel that the latter order of events is the commoner one. Psychoanalytic friends often criticize my methods of treatment by the following type of argument:

In taking alcohol away from your patients you are doing nothing to remove the unconscious mechanisms which have led to the alcoholism. The energy of these repressed complexes will find some other outlet—perhaps something worse than alcoholism—or more severe neurosis or psychosis will develop. This is a hypothesis which is not borne out by observed facts. I can say with confidence that all my successfully treated cases have become less nervous, not more, after treatment. Frequently symptoms of anxiety or tension have disappeared, and I have had one or two cases of combined alcoholism and sexual perversion in which, without any analytical procedure, the perversion ceased after the alcoholism had been treated. I have not known the reverse to happen.

Often of course—as one would expect in those cases where neurosis has been the basis of the alcoholism—the patient is left with psychological symptoms (usually improved) after he has become teetotal. In such cases appropriate psychiatric treatment is given—but not until *after* he has stopped drinking. In my opinion it is just as pointless to attempt to treat an alcoholic's neurosis whilst he is still drinking, as it would be to treat his cirrhosis or his peripheral neuritis.

When an alcoholic first presents himself for treatment he almost invariably has a strong sense of shame and failure but is on his guard against moral accusations or exhortations to use his will-power. An alcoholic doctor described the state as follows:

"The true addict has an intense dislike of himself, his habits, his behaviour, his reaction to his friends and normal individuals. He is the most supremely unhappy of mortals. He thinks life is finished, he imagines himself guilty of unspeakable infamies, he plumbs the depths of human experience; and yet the dreadful craving is always there for the drug which has been responsible for his misery."

The aim of the G.P.'s first interview should be to combat in some small way this attitude of the patient towards himself, the world in general, and his affliction. He must be surprised. He half expects a moral exhortation—there must be no hint of it. He expects to be asked to use his will-power—instead he is told that his will is quite powerless where alcohol is concerned—that he is suffering from an illness as a result of which he can no more by an effort of will stop drinking alcohol than a normal person could stop drinking water.

He must be given some ray of hope for the ultimate future that there is still a possibility that once again he will be able to live a reasonably happy and socially useful life. Above all he must be left to feel that he is an individual—an individual still of some interest and perhaps even worthy of some respect. I believe this point of "interest" is of real importance in winning the confidence and co-operation of any patient, alcoholic, neurotic, or physically ill, and one which I always stress to medical students in advising them how to develop a therapeutic relationship towards their patients.

The patient must be led to feel that he is no longer alone. The absolute aloneness which most alcoholics experience can be one of the most terrifying of their symptoms. Let him feel that at last there is someone prepared to be a friend to him—that he is no longer alone. To the same end it is helpful, preferably at the first interview, to introduce him to other alcoholics under treatment or who have been treated, preferably someone of similar intelligence and background—partly to inculcate a group feeling, partly as an object lesson that alcoholics are treatable, and partly to foster a sense of responsibility and usefulness in the treated alcoholic. For similar reasons I prefer to treat alcoholics in hospital in groups of two or three at a time rather than individually—moreover usually the treatment I give in hospital is rather unpleasant and a patient does not feel quite so sorry for himself if he sees in the next bed someone feeling equally miserable.

It is important to convince the patient early in one's handling of him that he is indeed an addict—that he will never be able to take an occasional glass of sherry without drinking too much. Treatment can make it fairly easy for him to become teetotal, but no treatment can enable him to become a controlled drinker. If after treatment, with apomorphine or anything else, he drinks at all he will inevitably relapse into alcoholism.

The patients who have suffered most as a result of their alcoholic excesses are those most likely to accept the belief that they are alcoholic addicts. The man of middle age who has lost his health, his earning capacity, his wife and his family, his social status and the respect of his friends, is much more likely to believe he is an addict than is the young student who has been reprimanded at college for his drunkenness. Unlike nearly every disease in the medical textbook, the likelihood of benefiting an alcoholic with treatment improves with increase in age.

Often a patient's relatives try to persuade me to ensure his admission to hospital by some trick or subterfuge. This I always refuse. If I am to be of any permanent help to the patient I must keep his confidence and trust. To be detected in untruths or tricks would ruin this confidence, consequently I always try to answer patients' questions as sincerely and accurately as possible—whether the questions are about the probable effects of continuing drinking, or about the unpleasantness of the treatment he will receive if he comes into hospital. The only hope of getting the truth from an alcoholic is to be truthful in return. Anyone who tries to influence an alcoholic by lies will certainly lose: the alcoholic is more practised in deceit and lies with greater facility.